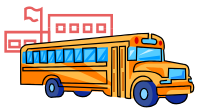

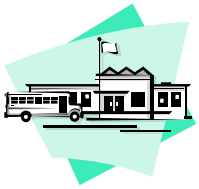

School-Based Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April, 2004

This publication supersedes all previous School-Based Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2003.

Updated October 2003, December 2003, January 2004, April 2004.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

Table of Contents

Prior Authorization (continued)

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, DPHHS information, services available, and legal information. • **Health Policy and Services Division:** See list under **Health Policy and Services Division** below.
Provider Information Website www.mtmedicaid.org or www.dphhs.state.mt.us/hpsd/medicaid/medicaid2	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.state.mt.us	• Information on the Children's Health Insurance Plan (CHIP)
Health Policy and Services Division **(Now Child and Adult Health Resources Division)** www.dphhs.state.mt.us/hpsd	• **Medicaid:** See list under **Provider Information Website** above, and Client Information is available also • **CHIP**: Information on the Children's Health Insurance Plan • **Public Health:** Disease prevention (immunizations), health and safety, health planning, and laboratory services • **Administration:** HPSD budgets, staff and program names and phone numbers, program statistics, and systems information. • **News:** Recent developments
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Covered Services

General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA)
- The services are written into an Individual Education Plan (IEP)
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all clients without charge.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in the *School-Based Services* manual and the *General Information For Providers* manual. School-based services provided to Medicaid clients include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology and audiology)
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services
- Specialized transportation

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply (see the *PASSPORT and Prior Authorization* chapter in this manual.

Services within scope of practice (ARM 37.85.401)

Services provided under the school-based services program are covered only when they are within the scope of the provider's license.

Provider requirements

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher's aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

Provider Type	Provider Requirements
Private duty nursing services provided by: • Licensed registered nurse • Licensed practical nurse	Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration.
Mental health services provided by: • Credentialed school psychologist • Licensed psychologist • Licensed clinical professional counselor • Licensed clinical social worker	Mental health providers must be licensed according to Montana's state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement.
Therapy services provided by: • Licensed occupational therapist • Licensed physical therapist • Licensed speech language pathologists	These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board.
Personal care paraprofessional	No licensing requirements

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner's license, certification, registration or credential to practice in Montana. Suspended Medicaid providers may not provide school-based services.

IEP requirements

Services provided to Medicaid clients must be covered by Medicaid and documented in the client's Individualized Education Plan (IEP). Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

Authorization Requirements

Service	Prior Authorization	PASSPORT Provider Approval	Written Physician Order/Referral
CSCT services	**No**	**No**	**No**
Therapy services	**No**	**Yes**	**No**
Private duty nursing services	**Yes**	**Yes**	**Yes**
School psychologist and mental health services	**No**	**No**	**No**
Personal care paraprofessional services	**No**	**Yes, if applicable** (If the client is enrolled in PASSPORT, PASSPORT provider approval is required.)	**Yes, if applicable** (If the client is not enrolled in PASSPORT, the client's primary care provider must provide a written order/referral.)
Specialized transportation services	**No**	**No**	**No**

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The school-based services in this manual are not covered benefits of the Mental Health Services Plan (MHSP). However, the mental health services in this chapter are covered benefits for Medicaid clients. For more information on the MHSP program, see the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The school-based services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part B crossover claims

Medicare Part B covers outpatient hospital care, physician care, and other services including those provided in a school setting. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their Medicare provider number on file with Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim with a copy of the Medicare EOMB to Medicaid for processing.

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

Remember to submit Medicare crossover claims to Medicaid only:

- When the referral to Medicaid statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.
- When Medicare denies the claim.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

If a parent determines that billing their insurance would cause a financial hardship (e.g., decrease lifetime coverage or increase premiums), and refuses to let the school bill the insurance plan, the school cannot bill Medicaid for these services based on requirements of IDEA.

If a parent refuses to let the school bill their insurance plan, Medicaid cannot be billed either.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Billing for Medicaid covered services when no IEP exists

In order to bill for Medicaid covered services that are not in the client's IEP, the school must meet all the following requirements:

- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

If the school bills private pay clients, then they must bill as follows for the services provided:

Client Insurance Status	Billing Process
Medicaid only	Bill Medicaid
Private pay, no Medicaid	Bill family
Private insurance/Medicaid	Bill private insurance before Medicaid
Private insurance, no Medicaid	Bill private insurance

Billing for Medicaid covered services under an IEP

If a child is covered by both Medicaid and private insurance, and the services are provided under an IEP, providers must bill as follows:

Client Insurance Status	Billing Process
Medicaid only	Bill Medicaid
Private pay, no Medicaid	Not required to bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid	Not required to bill private insurance

*Under IDEA, schools must have written parental permission before billing third party insurance.

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- When a child is covered under BlueCross BlueShield or CHIP, providers may bill Medicaid first since these insurances do not cover services provided in a school setting.
- Medicaid must be billed before IDEA funds are used.

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, include a note with the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:

1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "prior payments" form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance EOB when billing Medicaid.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim and submit to Medicaid. If a "blanket" denial is provided, the Department will accept and allow this denial for a period of no more than two years. The school must include a copy of this "blanket" denial with each submission for health-related services for each client. The "blanket" denial must be specific to the provider, client, and health-related services provided to the client. Blanket denials issued to schools without a client's name will not be accepted.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Include a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company) with the claim.
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*). When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the services before billing Medicaid for the services.

Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

Coding Tips

Effective January 1, 2004, the procedure codes listed in the following table will be the only valid procedures for schools to use for billing Medicaid. Although schools may continue to utilize the procedure codes published in the July 2003 fee schedule until that time, it is recommended that providers use only the following procedure codes.

Any codes billed by schools on or after January 1, 2004 that are not listed in the following table, will be denied.

School-Based Services Codes

Service	CPT Code	Unit Measurement
Occupational Therapist		
Occupational therapy – individual therapeutic activities	97530	15 minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation	97003	Per visit
Occupational therapy re-evaluation	97004	Per visit
Physical Therapist		
Physical therapy – individual therapeutic activities	97530	15 minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation	97001	Per visit
Physical therapy re-evaluation	97002	Per visit
Speech Therapists		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
Private Duty Nursing		
Private duty nursing services provided in school	T1000	15 minute unit
School Psychologist/Mental Health Services		
Psychological therapy – individual	90804	Per 30 minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation and re-evaluation	96100	Per hour
CSCT Program		
CSCT services	H0036	15 minute unit
Personal Care Paraprofessionals		
Personal care services	T1019	15 minute unit
Special Needs Transportation		
Special needs transportation	T2003	Per one-way trip

Using modifiers

School-based services providers only use modifiers for coding when the service provided to a client is not typical. The modifiers are used in addition to the CPT codes. The following modifiers are typically used in schools:

- Modifier "52" is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.

- Modifier "22" is billed with the procedure code when a service is greater than the customary service normally entails. For example, this modifier may be used when a service is more extensive than usual or there was an increased risk to the individual. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- Modifiers may also be required when providing two services in the same day that use the same code. See *Multiple Services on Same Date* for more information.

Multiple services on same date

When a provider bills Medicaid for two services that are provided on the same day that use the same CPT code and are billed under the same provider number, a modifier should be used to prevent the second service from being denied. The modifier "GO" is used for occupational therapy, and "GP" is used for physical therapy. For example, a school bills with one provider number for all services. The school provided occupational therapy for a client in the morning, and physical therapy for the same client in the afternoon of October 14, 2003. The claim would be billed like this:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	14	03	10	14	03	03	0	97530	GO	1	$ 22 00	1				
2	10	14	03	10	14	03	03	0	97530	GP	1	$ 22 00	1				

Time and units

- A provider may bill only time spent directly with a client. Time spent traveling to provide a service and paperwork associated with the direct service cannot be included in the time spent providing a service.
- Some CPT codes are designed to bill in units of 15 minutes (or other time increment) and others are "per visit".
- If the service provided is using a "per visit" code, providers should use one unit of service per visit.
- When using codes that are based on a 15-minute time unit, providers should bill one unit of service for each 15-minute period of service provided. Units round up to the next unit after 8 minutes. Please use the following table as an average of the number of units of service to use. If the actual number of minutes providing a service falls between the range of minutes in the first two columns of the chart below, use the number of units in the third column.
- If a CSCT provider sees a client more than one time in a day, the entire time spent with the client that day should be totaled and billed once with the correct number of units as described in the following table.

Billing for Time in Units

Minutes Greater Than	Minutes Less Than	Number of Units
8	23	1
24	38	2
39	53	3
54	68	4
69	83	5
84	98	6
99	113	7
114	128	8

Place of service

As of January 1, 2004, the only place of service code Medicaid will accept is "03" (schools). Until then, schools may continue to use "11" (office).

Billing for Specific Services

The following are instructions for billing for school-based services. For details on how to complete a CMS-1500 claim form, see the *Completing a Claim* chapter in this manual.

Medicaid covered services provided under and IEP are exempt from the "free care" rule.

School-based providers can only bill services in the amount, scope, and duration listed in the IEP. Medicaid covered services provided under an Individual Education Plan (IEP) are exempt from the "free care" rule. That is, providers may bill Medicaid for a covered service provided to a client under an IEP even though they may be provided to non-Medicaid clients for free.

Assessment to initiate an IEP

When billing for assessments (evaluations), use the CPT code for the type of service being billed. When the unit measurement is "per visit", only one unit may be billed for the assessment/evaluation. If the evaluation is completed over the course of several days, it is considered one evaluation. Bill the date span with 1 unit of service, not multiple units of serivce. For example, a speech/hearing evaluation completed over a three-day period would be billed like this:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	23	03	09	26	03	03	0	92506		1	$ 65 00	1				

A two-hour psychological assessment (evaluation) would be billed like this (the unit measurement for this code is "per hour"):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	23	03	09	23	03	03	0	96100		1	$ 90 00	2				

Comprehensive School and Community Treatment (CSCT)

If a provider spent 30 minutes in social skills training with a Medicaid client, it would be billed like this (the unit measurement for this code is 15 minutes):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
11	05	03	11	05	03	03	0	H0036		2	$ 40 00	2				

The CSCT program must follow the free care rule. That is, if it is free for non-Medicaid children, then it is free for all children.

The CSCT program must follow the *free care rule.*

Therapy services

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the supervising licensed therapist's Medicaid provider number. Remember to include the client's PASSPORT provider's PASSPORT approval number on the claim (field 17a of the CMS-1500 form). See the *Completing a Claim* chapter in this manual. Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is "15 minute unit"):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
12	02	03	12	02	03	03	0	97530		1	$ 40 00	2				

Private duty nursing services

Both PASSPORT and prior authorization are required for these services, so remember to include the PASSPORT provider's PASSPORT number and the prior authorization number on the claim (see the *Completing a Claim* chapter in this manual). Private duty nursing services provided for 15 minutes would be billed like this:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T1000		1	$ 5 00	1				

School psychologists and mental health services

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is "per 30 minute unit"):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	90804		1	$ 50 00	1				

Personal care paraprofessional services

Remember to include the client's PASSPORT provider number on the claim (see the *Completing a Claim* chapter in this manual). Personal care services provided to a client for 2 hours during a day would be billed like this (the unit measurement for this code is per 15 minute unit):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T1019		1	$ 24 00	8				

Special needs transportation

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a client was transported from his or her residence to school to receive Medicaid covered health-related services, and then transported back to his or her residence, it would be billed like this:

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of	Type of	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS		DAYS OR	EPSDT Family			RESERVED FOR
MM	DD	YY	MM	DD	YY	Service	Service	CPT/HCPCS | MODIFIER	CODE	$ CHARGES	UNITS	Plan	EMG	COB	LOCAL USE
09	02	03	09	02	03	03	0	T2003	1	$ 20 00	2				

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key*

Contacts). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999 - 888888888 - 11182003

Medicaid Provider ID	Client ID Number	Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **7-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. PASSPORT approval is different from prior authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim. Prior authorization is different from PASSPORT authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization does not match current information	• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual).

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 12-month filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used to override copayment and PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Overrides

Code	Client/Service	Purpose
1	EPSDT	Overrides benefit limits for client under age 21
2	Family planning	Overrides the Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	Overrides Medicaid cost sharing and PASSPORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	Overrides Medicaid cost sharing on the claim
6	Nursing facility client	Overrides the Medicare edit for oxygen services on the **line**

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Sample Claim

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a**	Insured's ID number	Leave this field blank for Medicaid only claims. For clients with Medicare, enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Place of service* in the *Billing Procedures* chapter).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table earlier in this chapter).
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Electronic RAs are available for only six weeks on MEPS.

If a claim was denied, please read the description of the EOB before taking any action on the claim.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

PUBLIC SCHOOL
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:10/15/03 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM (10)	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	100103	100103	1	97530	23.74	23.74	N	
(9) ICN	00327411250000700								
		LESS MEDICARE PAID*******					21.25		
		CLAIM TOTAL*******				23.74	2.49 (17)		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	100203	100203	1	92507	53.54	0.00	N	
ICN	00327511250000800								
		100203	100203	1	92508	21.76	0.00 (17)	N	31MA61
		CLAIM TOTAL*******				75.30			
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	100303	100203	1	90804	51.67	0.00 (17)	N	133
ICN	00327611250000900	100203	100203	1	92507	53.54	0.00	N	133
		CLAIM TOTAL*******				105.21			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason and remark codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

The credit balance section is informational only. Do not post from credit balance statements.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations (see *Credit balances* #2 above) to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

Rebill denied claims only after appropriate corrections have been made.

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim (not an adjustment).

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information, and submit to Medicaid.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Billing Procedures* chapter*, Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS: Public School / Name: 2100 North Main Street / Street or P.O. Box: Western City, MT 59988 / City State Zip
2. CLIENT NAME: Jane Doe
3. INTERNAL CONTROL NUMBER (ICN): 00327211250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT ID NUMBER: 123456789
6. DATE OF PAYMENT: 10/15/02
7. AMOUNT OF PAYMENT $: 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	10/01/02	10/02/02
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 10/31/03

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*. You may also order forms from Provider Relations or download them from the Provider Information website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Electronic RAs are available for only six weeks on MEPS.

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA*.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Manager of the DPHHS Technical Services Center (see *Key Contacts)*	DPHHS address on the form

Appendix A: Forms

- ***Montana Medicaid/MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Audit Preparation Checklist***
- ***Request for Private Duty Nursing Services***
- ***Paperwork Attachment Cover Sheet***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Request for Private Duty Nursing Services

MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION

==========

P.O. Box 6488
Helena, Montana 59604

Phone# 406-443-4020 or 1-800-262-1545 ext 150
Fax #: 406-443-4585

==========

REQUEST FOR AUTHORIZATION OF PRIVATE DUTY NURSING SERVICES

Complete all areas, which apply to the recipient:

Medicaid #: _____SEX___DOB_____
Name: Last_____First_____MI___
Address: _____ City: _____ State: _____Zip: _____
Provider #: _____Provider Name: _____ Location: _____
Phone #: _____Fax: _____
Signature of person completing review: _____

==========

NUMBER OF HOURS REQUESTED PER DAY: _____

Physician Name: _____Diagnosis: _____
Reason services are being requested: _____

==========

SCHOOL SERVICES: (Complete all blanks in this section)

* Date school year starts: _____ Date school year ends: _____
* Attends how many days a week: _____ Daily schedule: _____
* Who actually administers medications to students: _____
* Can med administration times be shifted so they do not have to be given at school? _____
* Medications to be given / freq.: _____
* Other skilled needs type / freq. IE: (catheterization, wound care)_____

==========

HOME SERVICES: Tube feeding /amount /frequency (attach copy of history and physical _____ and DR orders)

_____

*Routine Meds / frequency: Suction / Respiratory treatments:_____

_____ _____
_____ _____
_____ _____

OTHER SKILLED NEEDS (IE: sterile dressings B.I.D.)

_____ _____
_____ _____
_____ _____

If medications or treatments are ordered PRN- keep accurate records of date, times and duration of treatments. Submit a request for additional units at the end of the date span.

Foundation Use Only: Review Type:_____ **Review Category:** _____
Approved: From_____ **Thru**_____ **hour units**_____
Denied: From _____ **Thru** _____ **hour units**_____ **codes:** _____

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Bundled
Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of "N".

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Children's Special Health Services (CSHS)
CSHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

CPT-4
Physicians' ***Current Procedural Terminology, Fourth Edition***. This book contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

Credit Balance Claims
Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Electronic Funds Transfer (EFT)
Payment of medical claims that are deposited directly to the provider's bank account.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Explanation of Medicare Benefits (EOMB)
A notice sent to providers informing them of the services which have been paid by Medicare.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Free Care Rule
If a service is free to non-Medicaid clients, then it must also be free to Medicaid clients. Medicaid cannot be billed for services that are provided free to non-Medicaid clients.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

HCPCS
Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.

Health Insurance Portability and Accountability Act (HIPAA)
A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

ICD-9-CM
The International Classification of Diseases, 9th Revision, Clinical Modification. This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Internal Control Number (ICN)
The unique number assigned to each claim transaction that is used for tracking.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) website that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

PASSPORT Authorization Number
When a PASSPORT provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Pay and Chase
Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim
These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for client eligibility information.

Potential Third Party Liability
Any entity that may be liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Protocols
Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must by updated and approved by a physician at least annually.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reason and Remark Code
A code which prints on the Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the Reason/Remark codes is found at the end of the RA (formerly called EOB code).

Referral
When providers refer clients to other Medicaid providers for medically necessary services that the PASSPORT provider does not provide.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Restricted Card
When utilization of services is excessive, inappropriate, or fraudulent, a client is restricted to designated providers.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

School-Based Services
Medically necessary health-related services provided to Medicaid eligible children up to and including age 20. These services are provided in a school setting by licensed medical professionals.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
    - the date of service
    - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

Index

C

D

E

F

N

O

P

Q

R

S

T

U

V

W

Z